Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Telemedicine Pre-Registration

Please attach all pertinent clinical and diagnostic information to this form and fax (206-729-3063). For questions call Gerry Rodriguez at 206-987-1771.

Today's date:

PATIENT	**Last Name:**	**First:**	**M.I.:**
Date of Birth:		☐ **Male** ☐ **Female**	
Language spoken at home:		**Patient Race/Ethnicity:**	
Mother's Full Name:		**Father's Full Name:**	
LEGAL GUARDIAN	☐ **Mother** ☐ **Father**	☐ **Other Guardian Name:**	**Relation to Patient**:
Address:			
Home Phone:		**Work Phone:**	**Cell Phone:**
PATIENT LIVES WITH	☐ **Mother** ☐ **Father**	☐ **Other Guardian Name:**	**Relation to Patient:**
Address:			
Home Phone:		**Work Phone:**	**Cell Phone:**
Referring Physician:			
Primary Care Physician: **PCP Address:**			
PCP Contact Number:		**Fax Number:** **Email Address:**	
Therapist:	**Ph. Number:**	**Fax Number:** **Email Address:**	

WHAT DO YOU WANT FROM THIS CONSULTATION? – Please be brief:

REFERRAL CONCERNS RELEVANT TO CONSULTATION - please be brief:

RECORDS TO ATTACH:

1) Therapist Intake Notes / Notes from referring party i.e. PCP, school,
2) Medication trial notes / Current Medication and dosage
3) Other major medical conditions
4) IEP and the assessment used to establish the IEP